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ABSTRACT

In order to explore attitudes toward female and male suicidal behaviors, psychologists (N=38), social workers (N=45), registered nurses (N=44), and lay persons (N=41) were asked to complete the Suicide Opinion Questionnaire (Domino et al., 1982). Half of the questionnaires for each group referred to a female target person and half referred to a male. The results indicated that the psychologists and social workers were the most accepting in their attitudes, and generally most knowledgeable about suicide. The community group appeared to be the least accepting of suicidal behavior, and were least aware of high risk factors. Among the professional groups, clear differences emerged in the seriousness accorded certain suicidal behaviors, and in the perceived character and motivation of the suicidal person. Differences also emerged in the perceptions of male and female suicide. Suicide was viewed as a viable option for males as an escape from life's problems. The suicidal behavior of females was seen as less sincere, more manipulative, less serious, and in some sense less important than that of males. An ultimate goal would be to ensure that service providers from various disciplines do not function at cross-purposes, either among themselves or in conjunction with attitudes held by non-professionals in the community. (LLL)

Attitudes Of Professional And Community Groups Toward Male and Female Suicide

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Running head: ATTITUDES TOWARD SUICIDE

Abstract

Further to the work of Broverman et al. (1972) and others, this study explored whether different attitudes exist toward female as opposed to male suicidal behaviours, and, in turn, whether these conceptions would vary according to one's professional discipline. Psychologists (N=38), social workers (N=45), registered nurses (N=44), and 41 lay persons completed the Suicide Opinion Questionnaire (Domino et al., 1982). Half of each group's questionnaires referred to a female target person, and half referred to a male. Judged seriousness of behaviour for males vs. females was significantly different on 22 items, and significant differences between professional groups appeared on 35 items. Some female suicidal behaviours were perceived as less serious than were the same behaviours when performed by a male. Further analyses, and implications for theory and practice in the community, are outlined.

Attitudes of Professional Groups Toward Male and Female Suicide

This study investigated attitudes toward suicide as expressed by psychologists, registered nurses, social workers, and lay persons, using the Suicide Opinion Questionnaire (SOQ) developed by Domino, Moore, Westlake, & Gibson (1982). The SOQ is a 100-item inventory, measuring various aspects of suicide such as its perceived acceptability, relevance to mental illness, lethality and perceived causation.

Frequently, in professional practice in the community, different groups often confront present or potential suicidal persons and must decide upon appropriate intervention. Effective intervention, however, depends upon meaningful cooperation and some consensus of attitudes toward suicide, both within and between disciplines. Little research, to date, has been concerned with this aspect of the problem. Since some SOQ items test factual knowledge about suicide, and others are attitudinal in nature, the present study was able to examine each group's knowledge, as well as attitudes about the issue, thus enabling between-group comparisons in both realms.

A second concern of the present study derives from the research of Broverman et al. (1972) and from an important issue to which attention has gradually been drawn, i.e., the question of different standards or conceptions of mental health for males as opposed to females (cf., Rosenfield, 1982; Greenglass, 1981; Rohrbaugh, 1979; Hyde & Rosenberg, 1980). This issue is relevant to theory about mental health, and ultimately to differences in the perceived seriousness of possible suicidal behaviour. Thus, in the present study, the SOQ was modified so that half of the subjects received a "male" and half a "female" version of the questionnaire, as described below.

A third concern was the examination of to what extent the groups endorsed or did not endorse several alleged misconceptions about suicide, such as those typically reported in recent texts (e.g., Bootzin & Acocella, 1984). Clearly, community resources and intervention are less effective to the extent that lay, or even professional, groups

subscribe to such misconceptions. Some of these myths (see Schneidman, 1981) are, for example, that the truly suicidal person does not talk about suicide beforehand, is "insane", or gives no warnings before the suicidal act.

A last concern was to examine the relationship of selected demographic variables (religion, age, and sex of respondent) to SOQ responses.

Method

Subjects

A total of 168 volunteer subjects participated. These were: professional psychologists registered in the province of Ontario (N=38), practicing social workers registered in Ontario (N=45), practicing nurses registered in Ontario (N=44), and a comparison group (N=41) of lay individuals from various community groups, i.e., undergraduate and graduate students, housewives, factory workers, teachers, engineers, and secretaries. Approximately half of each professional group, and of the comparison group, were male, and half were female.

Materials

A male and a female version of Domino et al.'s (1982) 100-item SOQ were used, as described. The 100 items were those selected from logical and statistical analyses from an initial pool of 3,000 items, which in turn were derived from a large survey of suicide literature (Domino et al., 1982). Each item (e.g., "Most people who commit suicide are lonely and depressed") was answered using a five-point Likert scale ranging from "strongly agree" to "strongly disagree." All subjects also indicated their age, sex, and religion.

Procedure

The psychologist and social worker groups were contacted by mail by the first author, asked to participate, and later returned their questionnaires by mail. Those in the nurses' group were solicited individually since each was employed at a large Ontario

psychiatric hospital in which the first author served as a summer intern. Subjects in the comparison group also were solicited individually through informal contacts by the first author.

For the male version of the SOQ, 76 of the 100 items were reworded so as to apply specifically to a male target person. The same procedure produced the female version. For example, "Most men who commit suicide are lonely and depressed" contained the word "women" in the female version, and so on. The remaining 24 items were necessarily retained in their original form, with sex unspecified, e.g., "Suicide goes against the laws of God."

Half of each group received the male, and half the female, questionnaire, i.e., in a 2 (sex of item) by 4 (group) analysis of variance design.

Of 265 questionnaires distributed overall, 168 (63.3%) were returned; 89 were "male" questionnaires and 79 were "female." For mailed questionnaires only, the return rate was 54%.

Results

Results were analyzed by (1) 2 (sex of item) by 4 (group) ANOVAs for each of the 100 SOQ items; (2) MANOVA analyses on selected item groups; (3) ANOVA and MANOVA analyses for items concerning misconceptions about suicide; (4) ANOVA and MANOVA analyses concerning subject demographic variables.

ANOVAs on SOQ Items

Using the SAS (1982) GLM procedure, 2 x 4 (sex of item x groups) ANOVAs were performed on each of the 76 items for which sex of the target person had been manipulated. One-way ANOVAs, with professional groups as the independent variable, were also performed on each of the remaining 24 items.

The effect for sex of item was significant at $p \leq .05$ on 22 (29%) of the relevant (i.e., changed) items. The effect for groups was significant at $p \leq .05$ on 35 of the 100

items. Interaction effects were significant at $p \leq .05$ on 12 (16%) of the relevant items, as shown in Table 1.

For a total of 54 items, at least one of the main, or interaction, effects was significant, i.e., at $p \leq .05$. Of the 22 significant effects for item sex, 16 occurred on attitudinal items, e.g. "Suicide prevention centers actually infringe upon a man's/woman's right to take his/her own life." Of the 35 significant effects for professional groups, again most (28) occurred on attitudinal items. Of the 12 significant interaction effects, five concerned attitudinal and seven concerned factual, items. Considerable variation thus occurred within and across the four groups, both in terms of attitudes toward male versus female suicidal behaviour as well as in perception of the factual aspects of suicide. The attitudinal differences were more numerous than these latter differences.

Insert Table 1 About Here

In addition, five items showed effects for item sex at $p < .08$; nine items showed effects at this level for groups, as did interaction effects for ten items.

For the 12 significant (i.e., at $p \leq .05$) interaction effects, effects for item sex were analyzed separately, by t-tests, within each of the four groups of respondents. Within the psychologists' sample, six such effects were significant at ≤ 0.5. Females, compared to males, were seen generally as less likely to commit suicide successfully, less likely to show suicide rates varying across cultures, less likely to disavow the rule of religion, and less likely to attempt suicide because of feeling "life is not worth living." Motivation, for females, was portrayed as more variable than for men, with suicide seen as a more "expressive" than "final" act.

For the social workers' sample, nine t-test comparisons were significant. Females were portrayed as less likely to commit suicide if black, less likely to commit "heroic"

suicides, less likely to commit suicide successfully, more likely to give warning signs, more likely to engage in dangerous sports to express an unconscious wish to die, less likely to be identified when the risk is serious, and more likely to be advised to undergo therapy in order to determine "inner motivation" for suicidal behaviour.

For the nurses' group, seven t-test comparisons were significant. In this group, "heroic" suicides among females were acknowledged more positively than for males. Suicide was less likely to be seen as a leading cause of death for females. Females were seen also as more likely to give warning signs, less likely to engage in dangerous sports due to unconscious factors, but again more strongly urged to undergo therapy to determine inner motivation, more likely to feel that life is not worth living, and again as being more difficult to identify when suicidal risk is serious.

For the community group, three comparisons were significant. "Heroic" suicide was valued more positively for males than for females. Females were seen as less likely to show culturally variable suicide rates, and less likely to disavow the role of religion in their lives

Analyses of Item Groups

Using the factor analytic results reported by Domino et al. (1982) as a guide, the SOQ items were categorized into 15 item groups, each representing a different aspect of opinions about suicide. These were: acceptability of suicide as normal in some circumstances (16 items); perception of suicide as mentally ill or immoral behavior (13 items); perception of suicide as "natural aggression" (seven items); perception of suicide as primarily a religious issue (five items); items concerning risk (e.g., broken homes) factors in suicide (four items); perceived lethality of suicide attempts (four items); emphasis on irreversibility (four items); items concerning demographic factors (three items); concern with the aging process and suicide (three items); impulsivity (three items); suicide as "getting even" (three items); items concerning the individuality of

motivation (three items); and items concerning sensation-seeking (three items).

For each item cluster, a groups x sex of questionnaire multivariate analysis of variance (MANOVA), using the SAS (1982) GLM procedure, was performed.

Of the 15 MANOVA analyses, significant effects for professional groups occurred on eight item clusters, significant sex of questionnaire effects occurred on 12 clusters, and significant interaction effects occurred on two.[1] For each MANOVA, the Hotelling-Lawley trace test criterion was used to assess significance levels for each effect.

For the first cluster (acceptability), the sex of item effect was significant, $F(16, 134) = 1.84$, $p < .03$.

For the second cluster (mental or moral illness), the sex of item effect was significant, $F(12, 144) = 3.13$, $p < .0006$. The effect for groups was significant, $F(36, 428) = 1.54$, $p < .02$.

For the third cluster (natural aggression), the group effect was significant, $F(21, 452) = 1.77$, $p < .02$.

For the fourth cluster (religion), the effect for sex of item, $F(5, 155) = 2.57$, $p < .02$, and for group, $F(15, 461) = 2.81$, $p < .0004$, were significant.

For the fifth cluster (risk factors), the effect for groups was significant, $F(12, 464) = 5.03$, $p < .0001$.

For the sixth cluster (lethality), the effect for groups, $F(12, 458) = 2.06$, $p < .02$, and for sex of item, $F(4, 154) = 3.03$, $p < .02$, were significant.

For the seventh cluster (normality), the effect for groups, $F(18, 446) = 1.83$, $p < .02$, and for sex of item were significant, $F(6, 150) = 2.44$, $p < .03$.

For the eighth cluster (irreversibility), the effect for groups, $F(12, 461) = 3.52$, $p < .0001$, and for item sex were significant, $F(4, 155) = 8.90$, $p < .0005$. The interaction was also significant, $F(12, 461) = 3.00$ $p < .005$.

For the ninth cluster (demographic aspects), the effect for groups was significant, $F(9, 461) = 4.12$, $p < .0001$.

For the tenth cluster (aging), the effect for groups was significant, $F(9, 464) = 2.29$, $p < .02$.

For the eleventh cluster (individuality), the effect for groups was significant, $F(5, 452) = 6.67$, $p < .0001$, as was that for item sex, $F(5, 152) = 6.36$, $p < .0001$, and for the interaction, $F(15, 452) = 2.70$, $p < .0006$.

For the twelfth cluster (impulsivity), the effect for groups, $F(6, 310) = 3.73$, $p < .0001$, was significant.

For the thirteenth cluster (attention-seeking), the effect for groups was significant, $F(9, 458) = 4.05$, $p < .05$. No effects were significant in cluster 14 (uniqueness of motivation).

For the fifteenth cluster (sensation seeking), item sex was significant, $F(3, 152) = 3.12$, $p < .03$.

Misconceptions About Suicide

Six items directly concerned popular misconceptions about suicide, i.e., that threats rarely are carried out, that suicide is more frequent among the very rich or very poor, that suicide is synonymous with mental illness, that most suicidal persons do not really want to die, that suicides occur without warning, and that those who survive an attempt will not likely try again. ANOVA results were examined specifically for each of these items.

For item 14, that threats are rarely carried out, the effect for groups was significant, $F(3, 159) = 5.88$, $p < .01$. For item 32, that suicides usually occur without warning, the effects for item sex, $F(1, 158) = 7.01$, $p < .01$, groups, $F(3, 158) = 4.35$, $p < .01$, and for the interaction, $F(3, 158) = 4.82$, $p < .01$, were significant. For item 56, that repeated attempts are unlikely, the effect for groups $F(3, 158) = 4.35$, $p < .01$, was

significant. For item 31, that most suicidal persons do not want to die, the effect for groups was significant, F (3, 160) = 2.59, $p<.05$. The six items assessing misconceptions about suicide were also subjected, as a group, to MANOVA analysis. Although the interaction was nonsignificant, the multivariate effect for groups, using the Hotelling-Lawley trace criterion, was significant, $F(18,452) = 2.64$, $p<.003$, with the effect for item sex marginally significant, $F(6,152) = 2.03$, $p<.06$.

Demographic Variables

One-way ANOVAs were also performed on each SOQ item with subjects' age, sex, and religion as independent variables.

Subject age was unrelated to responses, but the effect for religion (i.e., Catholic, Jewish, Protestant, Other, or None) was significant for ten items, i.e., at $p < .05$. These differences concerned: attitudes toward suicide notes, $F(4, 150) = 2.12$, $p < .05$; two items concerning incurable diseases and suicide, $F(4, 150) = 7.59$, $p < .01$, and $F(4, 150) = 4.00$, $p < .01$; compassion for victims, $F(4, 150) = 2.39$, $p < .05$; prior warning signs, $F(4, 150) = 2.23$, $p < .05$; environmental stresses, $F(4, 150) = 2.12$, $p < .05$; broken homes, $F(4, 150) = 2.66$, $p < .01$; the laws of God, $F(4, 150) = 3.18$, $p < .01$; importance of family ties, $F(4, 150) = 2.26$, $p < .05$; and the right to suicide, $F(4, 150) = 2.12$, $p < .05$.

For six items, sex of subject showed a significant effect, at $p < .05$. These differences concerned: attitudes toward business pressures, $F(1, 149) = 5.75$, $p < .01$; amenability to counselling, $F(1, 149) = 4.37$, $p < .01$; irreversibility of suicidal tendencies, $F(1, 149) = 4.46$, $p < .01$; suicide and the laws of God, $F(1, 150) = 3.96$, $p < .05$; burial practices, $F(, 150) = 4.40$, $p < .05$; and relevance of family size, $F(1, 150) = 13.85$, $p < .01$. The variables of subject sex and religion were also entered into a MANOVA analysis with the above items concerning misconceptions about suicide as dependent variables; none of the multivariate effects tested was significant.

Discussion

The results of this study indicated that the professional and lay groups differed on 35 items which assessed their views of suicide, its perceived causes, and the characteristics of the suicidal person. The psychologists and social workers were the most accepting in their attitudes, and generally most knowledgeable about suicide. The community group appeared to be the least accepting of suicidal behaviour, and were least aware of high risk factors (e.g., regarding the seriousness of threats, or future risk following an attempt). Among the professional groups, clear differences emerged, however, in the seriousness accorded certain suicidal behaviours, and in the perceived character and motivation of the suicidal person. These differences may precipitate or reflect disharmonies among professional groups, which may in turn affect strategies for intervention and community treatment.

Differences also emerged on 22 items regarding perceptions of male versus female suicide. In essence, suicide was viewed as a viable option for males as an escape from life's problems, but far less so for women. These differences suggest that males are seen as experiencing greater problems in living and experience more intense pressures than do females. It also suggests that males may in fact have fewer alternatives available to them when they are experiencing serious difficulties. Such attitudes, in turn, may derive from the prevalent sex role stereotype of the male as being unable to express his feelings, thus having fewer options available to him with which to deal with personal problems (see Middlebrook,1980).

One notable finding among the present results pertains to the perceived lethality of suicide attempts by males and females. The suicidal behaviour of females was seen generally as less sincere, more manipulative, less serious, and in some sense less important than that of males. These findings generally support the earlier findings of Broverman et al., (1972), and others, i.e., that among clinicians, different standards for

personal or psychiatric adjustment may in fact be held for males as opposed to females. These differences, thus appear to be present even among recognized professional groups (see also Waisberg, 1984). The sex of item differences between the present male and female questionnaires indicate also that, although such attitudinal scales generally are not analyxed for possible sexual bias (i.e., by analyzing for sex of item differences), such bias appears to affect subject responses.

Regarding misconceptions about suicide, the four groups clearly differed in their support of various fallacies. The professional groups appeared generally to be aware of the misconceptions, while the community group tended to agree with them, for example, that suicides usually happen without warning, that risk is lowered after an unsuccessful suicide attempt, and that those who threaten to commit suicide rarely do so. The community group also failed to recognize risk factors which would indicate suicide potential. The need for educational efforts regarding the meaning of suicidal behaviour thus arises, given that recognition of suicide potential is a first step towards prevention.

The results concerning demographic variables indicated that the respondent's religious affiliation and sex were both determinants of attitudes towards suicide. It was found that Jewish subjects, when compared to other religious groups, were relatively accepting of suicide, while Catholics appeared to be least accepting. Jewish subjects tended to believe people have the right to take their own lives, and seemed to be more aware of the importance of social variables (e.g., broken homes, poor family ties) as predisposing one to suicide. These results support the need for both professionals and lay persons to examine their own values and religious beliefs, as these may be factors which influence intervention and care.

Significant sex differences were found for subjects, with males tending to disagree with items concerning amenability of the suicidal person to counselling, and

the reversibility of suicidal tendencies. Male subjects also were more likely to see family size as a relevant factor in predicting suicide.

While the present study was largely exploratory in nature, it did reveal, in our opinion, that sizeable and multifaceted differences do exist both within and between professional groups now engaged both in professional and community care vis à vis the problem of suicide. These differences also were seen to reflect variation in attitudes toward the male versus the female suicide, sometimes depending, in turn, on the professional discipline of the respondent. While some of the differences were indeed consistent with factual truths, e.g., that females make more unsuccessful attempts, many of them in fact concerned attitudinal or philosophical issues, such as, for example, different perspectives on the alleged greater emotionality or intropunitiveness of the female (Caplan, 1984), the acceptability and dynamics of suicide for males versus females, or the supposedly greater meaningfulness of psychotherapy for females. Further exploration of attitudes about suicide is required, including future studies with perhaps a narrower focus than the one presently taken. However, if the number, nature and size of the attitudinal differences found in the present study, as well as of the differences in understanding of factual truths across different professional groups, are taken seriously, then such may reflect serious disharmony among different groups working with present or potential suicide victims. Specifically, the SOQ would appear potentially valuable as both a research and training instrument in this area. An ultimate goal would be to ensure that services by various disciplines do not function at cross-purposes, either among themselves or in conjunction with attitudes held by non-professionals in the community.

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This study is based in part upon a master's thesis, submitted by the first author to the Dept. of Psychology, University of Windsor, September, 1983. Portions of the study were also presented at the annual meeting of the American Psychological Assocation, Toronto, August, 1984.

Footnote

[1]More detailed reports of these results, including additional data tabulations, are available upon request.

Table 1 SOQ Items Yielding Significant Effects

Items Significant at $p < .05$ For Sex of Item Effect

1. Most suicides are triggered by arguments with a spouse.

12. In Canada, suicide by shooting is the most common method used.

20. Some people commit suicide as self-punishment.

21. Different cultural child-rearing practices are probably unrelated to suicide.

30. Over the last 10 years, the suicide rate in this country has increased greatly.

31. Suicides tend to happen without warning.

32. A business executive arrested for fraud or other illegal practices shouli face punishment (like a man) rather than seek suicide as an escape.

42. A rather frequent message in suicide notes left by victims is one of unreturned love.

48. Once a person is suicidal, he is suicidal forever.

49. There may be situations where the only reasonable solution is suicide.

52. Improvement following a suicidal crisis indicates the risk is over.

53. People engaging in dangerous sports like auto racing probably have an unconscious wish to die.

55. Suicides among young people (e.g., college students) are particularly puzzling since they have everything to live for.

60. Many victims of fatal auto accidents are unconsciously motivated to commit suicide.

66. Suicide rates are a good indicator of the stability of a nation; that is, the more suicides, the more problems a nation is facing.

67. Sometimes suicide is a person's only escape from life's problems.

73. Heroic suicides (i.e., the soldier throwing himself on a live grenade) should be viewed differently from other suicides.

81. People who commit suicide lack solid religious convictions.

91. The large majority of suicide attempts result in death.

92. Some people are better off dead.

93. Suicide attempters, as a group, are less religious.

96. Most people who attempt suicide fail in their attempt.

Items Significant at $p < .05$ For Groups Effect

5. Suicide prevention centres actually infringe on a man's right to take his life.

12. In Canada, suicide by shooting is the most common method used by men.

14. Men who threaten to commit suicide rarely do so.

18. Suicide is an acceptable means to end an incurable disease.

24. John Doe, age 45, has just committed suicide. An investigation will probably reveal that he has considered suicide for quite a few years.

25. Suicide is acceptable for aged and infirm men.

26. The suicide rate among physicians is substantially greater than for other occupational groups.

28. Different cultural child rearing practices are probably unrelated to suicide rates.

29. Suicide is clear evidence that males have a basically aggressive and destructive nature.

31. Most men who try to kill themselves don't really want to die.

32. Male suicides happen without warning.

46. In times of war, for a captured soldier to commit suicide is an act of heroism.

48. Once a person is suicidal, he is suicidal forever.

49. There may be situations where the only reasonable resolution for a man is suicide.

51. The suicide rate is higher for minority groups such as blacks and Canadian Indians than for whites.

52. Improvement following a suicidal crisis indicates that the risk is over.

56. Once a person survives a suicide attempt, the probability of his trying again is minimal.

58. Men who attempt suicide and live should be required to undertake therapy to understand their inner motivation.

61. If a culture were to allow the open expression of feelings, like anger and shame, the suicide rate would decrease substantially.

62. From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated.

63. Men who attempt suicide using public places (such as a bridge or tall building) are more interested in getting attention.

64. A man whose parent has committed suicide is a greater risk for suicide.

65. External factors, like lack of money, are a major reason for suicide.

68. Suicide is a very serious moral transgression.

70. If a man wants to commit suicide, it is his business and we should not interfere.

73. Heroic suicides (i.e., the soldier in war throwing himself on a live grenade) should be viewed differently from other suicides (i.e., jumping off a bridge).

75. Usually relatives of a suicide victim had no idea of what was about to happen to him.

78. Suicide goes against the laws of God and/or of nature.

80. Men who attempt suicide are usually trying to get sympathy from others.

82. Men with no roots or family ties are more likely to attempt suicide.

83. Men who bungle suicide attempts really did not intend to die in the first place.

91. The large majority of suicide attempts by men result in death.

92. Some men are better off dead.

94. As a group, men who have committed suicide experienced disturbed family relationships when they were young.

95. Men do not have the right to take their own lives.

97. Those men who commit suicide are cowards who cannot face life's challenges.

Items Significant at $p < .05$ For Interaction Effect

3. The suicide rate is higher for black males than for white males.

17. In Canada, suicide is the leading cause of death in males.

22. Suicide rates for men vary greatly from country to country.

32. Male suicides happen without warning.

53. Men who engage in dangerous sports like automobile racing probably have an unconscious wish to die.

58. Men who attempt suicide and live should be required to undertake therapy to understand their inner motivation.

73. Heroic suicides (i.e., the soldier in war throwing himself on a live grenade) should be viewed differently from other suicides (i.e., jumping off a bridge).

77. Suicide attempts by men are typically preceded by feelings that life is no longer worth living.

91. The large majority of suicide attempts by men result in death.

93. Men who attempt suicide are, as a group, less religious.

96. Most men who attempt suicide fail in their attempt.

100. Men who are high suicide risks can be easily identified.